The Duty to Care of Healthcare Professionals: Ethical Issues and Guidelines for Policy Development[1]

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[1] The opinions expressed herein are those of the authors and do not necessarily reflect those of the organizations for whom they are employed.

Providing care for patients during the SARS crisis placed many healthcare professionals in a position of significant risk—risk to their health and well-being and risk to the health and well-being of their family members, friends, and colleagues. Those who directly cared for individuals suffering from SARS were in the group at the highest risk of contagion. Even after the introduction of appropriate infection precautions including personal protective equipment, healthcare providers who participated in invasive procedures with SARS patients in the context of intensive care, remained susceptible to the virulent and potentially deadly virus. Many healthcare providers became ill with SARS; several died. Because of the potential harms associated with contracting SARS, a number of healthcare professionals in many settings (e.g., inpatient/outpatient, acute care/long-term care, community) raised questions about their duty to care, with some ultimately refusing to work. In this discussion paper, the specific issues and concerns that arose around the notion of a duty to care are identified and described. The underlying ethical values and value conflicts are examined. We conclude with policy guidelines that balance the healthcare professionals' duty to care with a set of reciprocal responsibilities of government, employers, and healthcare colleagues to healthcare professionals. Although the proposed policy guidelines were developed in response to the experiences of healthcare providers during the SARS crisis, they are broad enough to apply in the context of any public health emergency in outbreak conditions.

Methodology

A consistent methodology was used to analyze the issues and underlying ethical values and value conflicts that arose around the duty to care and to suggest practical

approaches for developing and implementing policies related to the duty to care in case of future infection disease outbreaks. Towards this end we relied heavily on the methodology of Philosopher/Theologian Bernard Lonergan (1973). His work on method provides a series of steps that move from experience, to understanding, to judgment and on to decision or action. His method is appropriate with regard to this topic as it focuses on the experiences of the human person who struggles to do good. The struggle to do good was acutely evident throughout the SARS crisis as health care providers and institutions sought to keep the needs of individual patients at the forefront as they coped with competing demands and conflicting values in the context of a constantly changing and uncertain environment.

We began by looking at the experiences of health care workers and institutions related to the duty to care by gathering and reviewing the following data:

1. Responses to the questionnaire sent out by the Expert Panel on SARS and Infectious Disease Control.
2. Summaries of the submissions by individuals, organizations, and facilities to the Campbell Commission; and
3. Transcripts of a sampling of full submissions by individuals, organizations, and facilities to the Campbell Commission including the facilities where most SARS patients were hospitalized.

Through a thematic analysis of these texts, several recurring and important issues relating to duty to care emerged as follows:

1. Heroism
2. Emotional Distress

3. Caring for Colleagues

Each of these will be described in greater detail below.

Issues and Concerns

Heroism

In reviewing the data, numerous references to the notion of heroism were evident throughout the data, particularly in the oral submissions made to the Campbell Commission. Individuals, organizations, and institutions framed heroism in many different ways: as doing the ordinary under extraordinary circumstances; as going above the call of duty; and as placing one's health and well-being, and even his/her life, at risk. The descriptions of heroism in the transcripts were compelling and several passages that poignantly capture this theme are included below.

> In the face of fear and isolation, nurses demonstrated incredible commitment to patients, to the healthcare system and to the profession. Even though they recognized personal risk, their duty to care took priority.
>
> If needed in the future, we will do it all over again. No effort will be too great. Treating patients is our professional reward and to rise to a new challenge on behalf of our patients is simply one of the most rewarding things that can happen in a professional life.
>
> People went above and beyond the call of duty, sacrificing their personal lives, dealing with the anxiety of families and friends, to care for their patients.
>
> As for my feelings and the feelings expressed by many of my nursing colleagues, we became nurses first of all to give care regardless of the diagnosis. Although our commitment was put to the test, together as a team, we were able to give care to our patients in an efficient, safe and caring way.
>
> SARS reinforced our belief that Ontario healthcare staff are hardworking, dedicated and courageous.
>
> Despite how vulnerable they are and were and how fearful they felt, they stayed at their patients' bedsides.

Although administrators reported being proud of their staff and their professional approach to the SARS crisis, they were quick to add that "it did not come without enormous personal sacrifice, particularly among our front-line care providers." For some, that sacrifice included death. Many other healthcare providers became ill and infected members of their families, friends, and colleagues. Unlike police and firefighters who "have an innate understanding of the dangers of their jobs," most healthcare workers had not previously considered illness and death as possible outcomes of working in their chosen professions.

Emotional Distress

For healthcare professionals working in the midst of the SARS crisis, the emotional toll was, and continues to be, great. Fear, isolation, exhaustion, and stigmatization were among the feelings expressed by healthcare providers. Staff members were worried about risks to their own health, but were even more concerned about spreading the disease to their families and friends, colleagues and other patients. In one of the submissions to the Campbell Commission, the plight of a Scarborough area doctor was described as follows. "She talks about getting up each morning, shaky and nauseated. She would vomit and then go to the office to see her patients. She said that she was not so much frightened for herself, but for her patients, but for her family. What if I killed them? Like hundreds of other doctors and nurses and other front-line staff, she got up, went to work, donned a mask, and cared for her patients. At the end of the day, sick with a headache from breathing her own carbon-dioxide all day, she would go home, isolate herself from her family and try to sleep." For some, even sleep did not provide an escape

from what some healthcare providers have described as hell. "I dream of disembodied mouths gasping for air and wake struggling to catch my own breath," one nurse said. "I dream of ventilators that turn into vacuums and suck up the air they are supposed to deliver. My sleeping self struggles to fix the problem before everyone suffocates." As days turned into weeks, and weeks into months, some healthcare professionals described the fear as paralyzing. "Of particular concern was the fear of exposure to SARS while carrying out more invasive care. Nurses also expressed fear that the protection available to them was inadequate—particularly during prolonged and often emergency procedures, such as intubations."

Work and home quarantines created another set of difficulties for healthcare providers. As one respondent noted, "At one point in time, one of our hardened intensive care doctors broke down in tears as a result of his ongoing fatigue and in our SARS unit when they were finally told that they did not have to stay in isolation any longer, in quarantine, it was almost a week before they could actually leave the ward. That's how ostracized they felt as a result of being in the situation of quarantine." The public's fear of contracting SARS resulted in discriminatory actions such as some healthcare workers' children being banned from daycares, healthcare professionals being refused dental and medical services, and friends and neighbours avoiding any personal contact. On a more positive note, one quarantined staff member expressed that "the only meaningful thing that brightened her day was a phone call from a member of the Department of Family Medicine. The caller simply asked how she was, and if she needed anything. That one act of kindness, that small effort, to let her know that someone cared, helped enormously to overcome what she was feeling."

Other contributing factors to emotional distress that were described included a perceived lack of information, a shortage of adequate protective equipment and supplies, and an insufficient degree of psychological and social support. Family physicians, for instance, "felt as if they were treated like mushrooms during the SARS crisis. They felt as if they were kept in the dark and fed manure, in terms of information." Similarly, the limited guidance as to whether or not certain groups of healthcare providers, such as those who were pregnant or immuno-compromised, should be directly involved in providing care for SARS patients, was distressing to many. Some respiratory therapists report being told "they were not frontline workers and thus did not need the good masks." Many expressed concerns about getting supplies and necessities such as masks, food, and prescription drugs to people who were quarantined. Psychological support, such as therapy for post-traumatic stress, was perceived as inadequate. There were limited references made in the data to situations in which healthcare providers refused to work. We know anecdotally, however, that given the perceived risks, the lack of adequate support, and the emotional distress associated with providing care for SARS patients, some healthcare providers were not willing to continue working under these conditions. Given the limited right of healthcare professionals to refuse to work under the Occupational Health and Safety Act, there was an expectation that the "Ministry of Labour had a heightened responsibility to respond to concerns [such as those identified above]." However, some expressed the view that this did not occur. Similarly the complaint was made that "nurses who were ill and the families of those who died have not received any extra compensation." This same respondent stated that "those [nurses]

who had SARS told me recently they want this government to give them an apology, [an] assurance of safety should they ever return to work and equitable remuneration."

Caring for Colleagues

For healthcare professionals who were in the position of providing care for their colleagues, the experience was often overwhelming. As one respondent eloquently stated, "I think if one tribulation stands out from SARS, it was the necessity of treating our own staff. The number of staff patients we had skyrocketed. At one point, we had 47 SARS patients and half of them were our own staff, including a number of physicians; that is perhaps the most memorable and haunting aspect of SARS, the surreal atmosphere. Here we had healthcare workers treating their colleagues who had become ill and critically ill by treating others in exactly the same environment. We had battle-hardened physicians and nurses in tears, faced with a situation for which no amount of training and experience could have prepared them." Similarly, for those healthcare professionals who became ill, being a patient "was a new and frightening experience for many. While some felt well cared for, several expressed concerns. Key issues related to delays in diagnosis and treatment, lack of emotional support and social isolation." In some instances, the decisions that were made by institutions reflected a sense of duty to care for colleagues. As one respondent stated, "when asked to become a SARS alliance hospital, they quickly stepped up to the plate. I can tell you that no one was thrilled with the idea, but it was their own colleagues, their co-workers, who had fallen ill and they wanted to bring as many of them as possible back into their own institution so that they could care for them themselves."

Underlying Ethical Values and Conflicts

A group from the University of Toronto Joint Centre for Bioethics identified ten ethical values that ought to influence decision makers who enter into the "balancing act" that is required in weighing competing goods in future public health emergencies (Upshur, 2003). These values included individual liberty, privacy, protection of the public from harm, protection of communities from undue stigmatization, proportionality, duty to provide care, reciprocity, equity, transparency, and solidarity. The experience of healthcare providers and the themes that emerged around heroism, emotional distress, and caring for colleagues point to many of these values and some actual and potential areas of conflict. An understanding of these underlying values and possible conflicts is a necessary prior step to providing ethically justifiable recommendations relative to providing guidelines around the duty to care in future public health emergencies in outbreak conditions.

Heroism

The archetypal characterization of the healthcare professional as hero was the dominant discourse in the submissions to the Campbell Commission. This reflects, we believe, a deep commitment of healthcare providers to the values of the duty to provide care and solidarity. SARS brought together teams of individuals from diverse disciplines, all in solidarity with the common goals of responding quickly and effectively to a public health emergency and providing exemplary care for all patients under extraordinary circumstances. The duty to provide care, in many instances, superseded the value of individual liberty. Many healthcare professionals were placed on work quarantines that

restricted their ability to move about freely in the community. Providing care to patients during the SARS crisis often meant that an individual's own health and well-being were placed at risk. Underlying the duty to provide care for patients is the presumption of a duty to provide care for the caregivers so that they can stay well and continue to perform this role. As a result, institutions put in place a variety of different mechanisms to minimize the risk of infection and help healthcare providers stay healthy. For example, persons with underlying conditions that made them more susceptible to infections like SARS or more likely to die from SARS were excluded from working in SARS units. Similarly, because of the potentially negative impact of SARS medications on a fetus, some institutions chose to send pregnant healthcare workers home for the duration of the SARS crisis. While healthcare providers were willing to sacrifice their own individual liberty and personal safety in order to fulfill their duty to care, they were often not willing to assume that same risk for their families and loved ones. Consequently, a number of healthcare providers voluntarily restricted contact with their families and loved ones in order to protect them from what they perceived as a disproportionate level of risk. Here the underlying conflict was between the value of a duty to provide care and that of protecting the public, including their family members, from harm.

The hero symbolism assigned to healthcare providers is powerful and compelling, but may not necessarily be totally benign. A hero is "a person distinguished by courage, noble deeds, and outstanding achievements" (Oxford, 2001). To suggest that each and every healthcare provider must achieve hero status may be an unrealistic, unattainable, and unsustainable goal. The notion of heroism in healthcare has been explored by several authors (e.g., Bowles, 1997; Cahn, 1987; Smith, 2002). Bowles (1997) suggests that

expectations of heroism exact significant personal costs that could be diminished by adopting a different philosophical stance with more realistic moral demands and creating an institutional climate that minimizes the need for heros.

Emotional Distress

While healthcare providers were committed to providing care for patients during the SARS crisis, there were associated personal costs and significant emotional distress. A perceived lack of transparency in decision-making processes and the flow of information created emotional distress for many healthcare providers. In particular, healthcare providers did not feel they were given sufficient information regarding infection control precautions and the level of risk associated with SARS. The community of healthcare workers often experienced stigmatization simply by virtue of their having worked in a healthcare environment. Being ostracized in this way significantly impacted their individual liberty as their ability to move freely about the community was compromised. The stigmatization that extended to the families and children of healthcare providers was a challenge to the value of proportionality, as these restrictions were neither legitimate nor necessary. This conflict of values heightened the level of emotional distress. Although not discussed at length in the data we reviewed, many healthcare providers experienced emotional distress as a result of a perceived lack of equity between the steps taken to manage SARS and the need to provide continuing access to other patients in need of health care. For example, many patients were denied access to surgical procedures and cancer treatments. However, what was perhaps the most significant contributor to emotional distress, was the perceived inadequacy of supports that were put

in place to mitigate the anticipated and actual harms for healthcare providers. As a result many experienced unresolved feelings of fear, isolation and exhaustion. This experience of abandonment and psychological isolation eroded the value of reciprocity and tested the limits of professional commitment. It was evident from the submissions that a stronger focus on and commitment to the value of reciprocity is essential if healthcare workers are to continue to be able to uphold the duty to provide care.

Caring for Colleagues

At its best, the experience of providing care to colleagues who were suffering from SARS exemplified the values of solidarity and reciprocity. However, this experience was often overwhelming and among the most challenging and unexpected for healthcare workers. For the most part, healthcare providers rallied around their ill colleagues and provided them with exemplary care and support. There were numerous instances where institutions and healthcare workers requested that sick colleagues be admitted to their home organization for care. However, at times this desire to care for one's own presented a challenge to the value of equity, particularly with the formation of alliance hospitals in the second wave of SARS, as not all hospitals were designated to accept SARS patients. In addition to requests to be involved in their medical care, healthcare colleagues and institutions provided a variety of different supports to their families. Perhaps for the first time, healthcare colleagues became part of a larger healthcare family and were viewed in a way that approximated that often seen in the context of police and firefighters who are harmed in the line of duty. This was a clear example of the value of reciprocity being lived out in practice. Unfortunately, not all

healthcare workers who became ill experienced this level of reciprocity as some healthcare professionals who contracted SARS felt alone and abandoned. Another of the values that was challenged in providing care for healthcare colleagues was related to privacy. Information about healthcare providers who were SARS patients was anxiously sought after by concerned colleagues and, at times, relatively accessible through medical records and conversations with healthcare providers.

Summary and Recommendations

In our analysis of the data, three themes around duty to care clearly emerged: heroism, emotional distress, and caring for colleagues. In examining the underlying ethical values and conflicts, we identified several ethical values that were compromised and others that were, at times, over-emphasized. Guidelines and policies related to the duty to care need to build upon the positive experiences of certain values that were lived out during SARS, while concurrently avoiding the unfavourable outcomes of compromised or over-emphasized values.

Guidelines for Developing Policies regarding Duty to Care during a Public Health Emergency

The following guidelines for developing policies regarding duty to care during a public health emergency in outbreak conditions flow out of the important ethical values (see Appendix A for definitions of values) identified previously. In the next section, a sample policy that incorporates these value-based guidelines and outlines a number of corresponding actions for achieving each guideline is provided. Many of the actions outlined

were utilized by some organizations during SARS; responders also identified other actions that did not take place, but would have been beneficial. Application of the guidelines and actions is not limited to an infectious outbreak of SARS, rather they are intended to inform duty to care in the context of any public health emergency in outbreak conditions.

Duty to Provide Care

1. Healthcare professionals have a duty to provide care to patients. This duty extends to a public health emergency in outbreak conditions.

2. Refusals to work should be handled in accordance with the Occupational Health & Safety Act.

Reciprocity

1. Employers have a reciprocal duty to protect and support healthcare employees.

2. Employers have a duty to provide necessary and sufficient information, human resources, protective equipment and supplies to maximally minimize risk of infection to employees.

3. When healthcare staff are quarantined at work or home, adequate supports must be provided to them and their families.

4. When healthcare staff lose hours of work due to other reasons such as an essential services only directive or 2 site control measures, adequate supports must be provided to them and their families.

5. Similar to the model articulated by firefighter organizations, healthcare employers have a special duty to provide care and support to employees who are harmed or die in the line of duty and to their families if they suffer harm.

Individual Liberty

1. Any restrictions to individual liberty should be legitimate, necessary and applied fairly.

Privacy

1. Personal information of staff, patients and staff who are patients should be maximally protected.

Protection of Communities from Undue Stigmatization

1. Healthcare professionals should be protected from undue stigmatization.

Protection of the Public from Harm

1. Healthcare professionals have a duty to protect the public from harm.

Transparency

1. Healthcare professionals have a right to receive truthful and complete information that is needed for them to fulfill their duty to care.

A Sample Policy for Duty to Care in a Public Health Emergency

Value	Guiding Principles	Procedures
Duty to Provide Care	Healthcare professionals have a duty to provide care to patients. This duty extends to a public health emergency in outbreak conditions.	1. Organizational codes of ethics for healthcare providers should include a statement that refers to the section in the Occupational Health and Safety Act that outlines healthcare professionals duty to provide care. 2. Employees should be informed of this duty and agree to honour it on their offer of employment and annually as part of their performance review.
Duty to Provide Care	Refusals to work should be handled in accordance with the Occupational Health & Safety Act.	1. Employers should explore the reasons for the employee's refusal to work and appropriately respond to legitimate concerns. 2. Employers should advise the employee that they are required to attend work and warn the employee that they may be subject to discipline should they choose not to attend.[2] 3. Work refusals require the employee to be present at the workplace to identify the specific unsafe work situation with their employer and joint Health & Safety Committee.[3]
Reciprocity	Employers have a reciprocal duty to protect and support healthcare employees.	1. At the outset of an outbreak condition, corresponding fitness to work guidelines should be developed by Ministry of Health & Long Term Care. (This may include excluding some staff from certain duties. For example, it might be appropriate to reassign immuno-compromised individuals to duties other than direct care of infectious patients.) 2. Employee Assistance Program (e.g., counseling, stress management) should be made available to staff.

[2] Human Resources Recommendations, SARS Human Resources Working Group, Ontario Hospital Association

[3] Human Resources Recommendations, SARS Human Resources Working Group, Ontario Hospital Association

Reciprocity	Employers have a duty to provide necessary and sufficient information, human resources, protective equipment and supplies to maximally minimize risk of infection to employees.	1. Clear and consistent information should be provided to employees in a timely and transparent manner. 2. Provide orientation and training programs as needed. 3. If needed, enhanced staffing models should be put in place.
Reciprocity	When healthcare staff are quarantined at work or home, adequate supports must be provided to them and their families.	1. Staff who are quarantined at home should be paid regular earnings for all scheduled shifts.[4] 2. Staff who are quarantined at work or home should be provided necessary supports to maintain family commitments (e.g., delivery of groceries, taking children to daycare). 3. A process for maintaining daily communications with each quarantined staff member should be put in place.
Reciprocity	When healthcare staff lose hours of work due to other reasons such as an essential services only directive or 2 site control measures, adequate supports must be provided to them and their families.	1. For loss of hours due to essential services only directive, staff should be paid regular earnings for all scheduled shifts.[5] 2. For loss of hours due to 2 site control measures, assistance to apply for EI should be provided.[6] 3. Employee Assistance Program (e.g., counseling, stress management) should be made available to staff. 4. A fund to cover interim emergency expenses should be established.

[4] Human Resources Recommendations, SARS Human Resources Working Group, Ontario Hospital Association

[5] Human Resources Recommendations, SARS Human Resources Working Group, Ontario Hospital Association

[6] Human Resources Recommendations, SARS Human Resources Working Group, Ontario Hospital Association

Reciprocity	Similar to the model articulated by firefighter organizations, healthcare employers and the government have a special duty to provide care and support to employees who are harmed or die in the line of duty and to their families if they suffer harm.	1. Assistance to make a WSIB claim should be given to staff who have work-related illness. [7] 2. A fund to cover interim emergency expenses should be established. 3. Employee Assistance Program (e.g., counseling, stress management) should be made available to staff and families. 4. Hospital insurance policies should be revised to include line of duty illness or death compensation. 5. Employers and healthcare providers should lobby federal and provincial authorities for adequate compensation for healthcare professionals harmed in the line of duty.
Individual Liberty	Any restrictions to individual liberty should be legitimate, necessary and applied fairly.	1. The least restrictive option for quarantine should always be chosen. 2. When the risks to a fetus are unknown or known to be harmful, pregnant women should be allowed to choose whether or not to work in areas with a high risk of infection and should be appropriately reassigned as necessary.
Privacy	Personal information of staff, patients and staff who are patients should be maximally protected.	1. Only that information which is needed to protect the public from harm should be released. 2. Unless the patient/colleague has consented to the release of information to specific others, only those individuals directly involved in the care of a patient/colleague should have access to personal information about the patient/colleague.
Protection of Communities from Undue Stigmatization	Healthcare professionals should be protected from undue stigmatization.	1. In all actions and communication, caution to avoid undue stigmatization of healthcare professionals should be taken.
Protection of the Public from Harm	Healthcare professionals have a duty to protect the public from harm.	1. Staff should refrain from working if they are feeling unwell. 2. Staff must comply with infection control measures and quarantine requirements.

[7] Human Resources Recommendations, SARS Human Resources Working Group, Ontario Hospital Association

Transparency	Healthcare professionals have a right to receive truthful and complete information that is needed for them to fulfill their duty to care.	1. Clear and consistent information and the corresponding rationale for infection control measures must be clearly communicated to staff. 2. A process for seeking clarification and questioning information should be in place.

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Appendix A: Definitions of Values[1]

Equity – dealing fairly and equally with all concerned

Individual Liberty – the quality or state of being free, the power of choice

Privacy – freedom from unauthorized intrusion

Proportionality – assigning a proper or equal share to attain balance or symmetry

Reciprocity – to give and take mutually, returning in kind

Solidarity – unity (as of a group or class) that produces or is based on community of interests, objectives, and standards

Transparency – free from pretense or deceit, readily understood

[1]Merriam Webster Dictionary (2003). Available on-line at http://www.m-w.com/dictionary.htm